# Patient Education In Primary Care

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## PATIENT EDUCATION RESPONDS TO NATIONAL PAIN INITIATIVES

The launch of a national VHA pain management strategy–Pain Assessment *The 5th Vital Sign*–and the roll-out of new JCAHO standards pertinent to pain management confronts primary care providers with an exciting but somewhat overwhelming challenge. How to educate providers and veterans alike about new pain management strategies, develop a common language to talk about pain and overcome stereotypes that may inhibit the delivery of appropriate pain-related services? While still at the beginning stages in many medical centers, staff are making headway in the development of various patient education activities and programs targeted to pain management.

### Building Awareness.

Given the large numbers of providers and patients who must be reached with information about the pain initiatives, VAMCs are using a range of small and large strategies to increase awareness.

- With veterans lack of experience talking about pain, primary care staff at the Grand Junction VAMC keep laminated sheets in all of their exam rooms with sample words (Figure 1) that may be used to describe individual values on the 0-10 pain scale. The Tomah, WI VAMC has a pain scale with 11 facial expressions; this type of scale has been particularly helpful for those over 70 years old.

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## WELCOME TO OUR RESOURCE FOR PATIENT EDUCATION AND PRIMARY CARE![1]

### WHAT IS IT?

The purpose of this tool is to provide a mechanism to help meet the challenges of incorporating effective patient teaching into primary health care.

### WHO IS IT FOR?

VA Primary Care Teams, Patient Health Education Coordinators or Patient Health Education Committee chairs, VISN and VAMC decisionmakers

## c o n t e n t s



1. This publication may be duplicated. It is also available on the VA website at http://www.va.gov/visns/visn02/emp/education/education.html.

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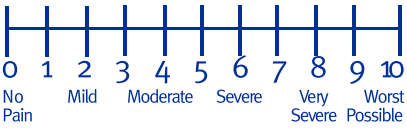
FIGURE 1

## PAIN

Your primary Care Team will ask you about your pain. Most people have pain from time to time. You will be asked to describe your pain with a number. The VA has decided to use a 0-10 scale.

*This may help you describe your pain.*




0=No pain

1=Slightly uncomfortable. Occasional minor twinges. No medicine needed.

2=Minor bother. No medicine needed.

3=Annoying enough to be distracting. Mild painkillers like Aspirin or Tylenol help.

4=Can be ignored if you are really involbed; still distracting. Mild painkillers help for 3-4 hours.

5=Can't be ingnored for more than 30 minutes. Mild painkillers help for 3-4 hours.

6=Can't be ognored, but you can still work. Stronger narcotic painkillers help for 3-4 hours.

7=Hard to concentrate, bothers sleep. You can still function. Painkillers only help some.

8=Activity limited a lot. You can read and talk with effort. Nausea and dizziness are part of the pain.

9=Unable to speak. Crying out or moaning.

10=Unconscious. Pain makes you pass out.

Adapted from Mankoski Pain Scale ©

*Reprinted with permission from the Grand Junction (CO) VAMC.*

- In Columbia, SC, the patient health education coordinator in collaboration with the primary care clinic has developed two single page handouts about pain and pain assessment–one for inpatients and one for outpatients (Figure 2). Staff find that these sheets have increased patient interest and made the assessment process easier for clinicians.
- A *"Rights and Responsibilities for Pain Management"* statement is now posted in waiting areas at the Hines IL VAMC. This information has also been featured this year on the January page of the Year 2000 Personal Health Calendar distributed to Hines' patients. Pain management will also be spotlighted in the April 2000 patient newsletter that is distributed through the Community Based Outpatient Clinics.
- With drug company support, the Albuquerque VAMC sponsored a well-received half-day program and lunch for veterans–"What You Need to Know About Pain." Presentations focused on how to talk with your provider about pain and medical as well as alternative therapies for management of pain.
- The *Kiss Pain Away* project at Tomah, on the other hand, has addressed increasing broad staff awareness of the pain management initiative and local resources. Five very brief e-mail messages describing VHA's national pain initiative, local programs and the process of pain assessment were sent out over a period of weeks to all clinical and administrative staff. Whoever was able to answer the short trivia question about pain at the end of each e-mail was rewarded with a chocolate kiss!

## More In-Depth Programs for Patients.

In addition to building awareness, VAMC's are strengthening their programs for chronic pain management. For example, the Director of Behavioral Medicine at the Charleston (SC) VAMC has just begun a "Coping with Pain" program for patients referred to the Pain Clinic; however, the medical center will be opening the program to any primary care patient who is in pain. An eight session, 90-minute per session, interactive program, the content includes

1) what is chronic pain,
2) pain medication and alternative therapies;
3) pain and your mood;
4) relaxation and imagery skills;
5) stress management;
6) how your family can help;
7) how exercise and diet can help; and
8) going on with your life.


**Teaching Tip**

At the New York VA Harbor Health Care System, nurses in ambulatory surgery offer anxious patients walkmen with progressive relaxation tapes.

For more information contact Rose Lester, RN, Team Coordinator for Ambulatory Surgery at (212) 686-7500, ext. 7829.

Richard Harvey, director, thinks there are several keys to success. First the program has to be interactive–patients have to be able to discuss issues and vent about their frustration with the medical system that they feel is not helping them. Second, although it has been very difficult thus far, it is important to involve spouses given the potential for the family to reinforce negative as well as healthy behaviors.

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Veronica Steffen, Clinical Director of Pain Services, Cincinnati VAMC has had some success encouraging wives to attend a similar pain management class with their husbands. She provides a booklet for family members (A "How to Manage" Manual for Families of Chronic Pain Patients) developed by pain management staff at Tampa (FLA) General Hospital that is very popular. It includes examples of things that their significant others might do/say and practical suggestions for how to help. In the future, however, she would like to see a separate program for families–"There are many separate issues and it is important for families to share their frustrations which they can't do if they are in a group with their significant others."

Another important part of program development is to be sure that the pain education program is in synchrony with other pain-related services. For example at Cincinnati, the patient education program is recommended as part of the comprehensive plan in the pain center to help the veteran manage his or her pain. When this collaboration is lacking, the program may be unsuccessful. A pain management patient education program at another VAMC failed because it was not well-integrated into a comprehensive pain evaluation and treatment program. While the primary care clinicians had requested and endorsed the program, once the class began it turned out that many medical, surgical and/or physical therapy options for relieving pain had not been discussed or attempted. Patients came to the class not only angry at the pain but angry that they were not receiving appropriate treatment. In addition, the medication management part of the program evaporated when medical staff promises to meet with patients were unfulfilled.

FIGURE 2

*What You Need To Know About*

## OUTPATIENT PAIN MANAGEMENT

### WHAT IS PAIN?

Pain is a way your body responds to injury or illness. Everybody reacts to pain differently.

### WHAT CAUSES PAIN?

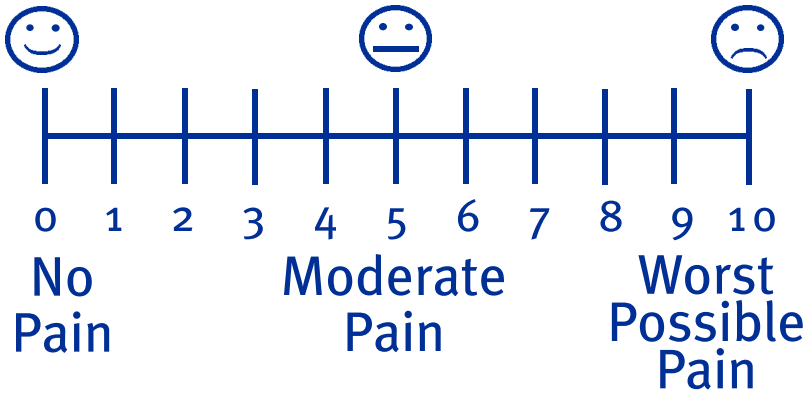
Pain can be caused by injury, surgery or disease. Some pain can be caused by pressure on a nerve, such as a cancer tumor or a back problem. Other pain may be caused when nerves are cut in surgery or in an accident. Sometimes there is no clear reason why people have pain. Most pain can be managed and controlled with medicine and other treatments. You and your primary care provider need to work together to find what pain control treatments are best for you.

### WHAT YOU CAN DO:

- You need to tell your primary care provider about your pain.
- You need to describe your pain (none, dull, sharp, cramping, stabbing).
- You need to rate your pain on a scale of 0 to 10.
- You need to tell your primary care provider if the medicine or treatment worked.

### WHAT YOUR PRIMARY CARE PROVIDER WILL DO:

- Explain to you about how the medical center staff will work with you about your pain.
- Ask you about your pain on a regular basis.
- Explain the type, amount and delivery method of your medicine.
- Ask you if you received the relief you expected from the medicine.
- Suggest other ways to help you be more comfortable.




*Reprinted with permission from the Columbia (SC) VAMC.*

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## Expanding Resources for Pain Management Education.

Building an environment that reinforces the importance of pain management education and service requires additional creativity. Some medical centers are implementing the concept of a "pain resource nurse" or a "pain resource professional" on every unit/service to serve as a role model and increase access to current information/resources on pain management. At Tomah, for example, Gloria Dettle, Hospice Coordinator combined the idea of pain resource professionals (PRPs) with recruiting staff who were dealing personally with chronic pain. These PRPs, once having received additional training in pain management have become a resource for others on their units and a conduit for new information coming into the medical center. Similarly at Cincinnati, it is expected that the one or two nurses from each unit who will become pain resource nurses will be able to encourage more accountability for addressing pain problems because of their own increased expertise and link with specialized pain management resources in the institution.

Another way that pain management can be made more visible in the organization is through improved access to pain management teaching resources. In addition to the assessment scales and flyers described earlier, other pain related educational materials should be available. For example at the New York Harbor Health Care System, a simple brochure on Patient Controlled Analgesia is available especially for those primary

care patients who will be having surgery. Other VAMCs have other types of reference materials available in their Patient Education Resource Centers.

Adapting an idea from the LaCrosse WI based Gunderson Clinic, Tomah is piloting a Purple Cart –with distraction therapies for pain management–to increase visibility for pain management on one inpatient unit. Purchased with a donation from the American Legion, this cart will contain humorous videos and audiotapes (with generationally specific options), aroma therapy materials (especially lavender oil for pain), aroma diffusers, foot massager, lotions, hard candies, information on guided imagery, massage and relaxation therapy directions–all accessed with the medication key. Gloria Dettle, Hospice Coordinator, reports that humor videos are the most popular but staff are interested in collecting a variety of tools that patients can use for distraction especially when they can't sleep. She also sees applicability to the outpatient setting where staff could use a Purple Cart to teach patients how to distract themselves at home.

*For further information about the strategies described in this article contact:*

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**Richard Harvey,** PhD, Director Behavioral Medicine, Primary Care Program, Charleston SC VAMC; 843/577-5011, Ext. 7138.

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## CLINICAL PRACTICE TRIVIA

For patients who smoke, what is the required number of times they should be counseled about tobacco risks/cessation?

*Three times a year according to the EPRP Chronic Disease and Prevention Indicators.*

## FLEXIBLE PAIN MANAGEMENT RESOURCE

Plain Management: Patient Education Manual (Aspen Publications) is a comprehensive resource in a convenient loose-leaf format. Yearly updates are also available. The manual includes easy-to-understand materials that can be duplicated for patients covering a wide variety for pain topics from specific types of pain to individual pain management strategies. For example, staff at one VAMC refer patients to the manual in the Patient Education Resource Center with a list of page numbers to read and/or copy.

FOR ORDER INFORMATION CALL 1-800-638-8437 or go to *www.aspenpublishers.com*

# HOW DO WE KNOW PATIENT EDUCATION WORKS?

## COMPUTERIZED PATIENT EDUCATION

A recent review of published articles related to the use of computer technology in patient education identified sixty-six articles including 21 research reports. Nearly half of the studies were related to the management of chronic disease. Thirteen of the studies described an improvement in knowledge scores or clinical outcomes when computer-based patient education was compared with traditional instruction. Additional articles compared patients' computer experience, socioeconomic status, race and gender and found no significant differences in program outcomes. Sixteen of the 21 research-based studies had effect sizes greater than 0.5, indicating a significant change in the described outcome when the study subjects participated in compute-based patient education.

*Lewis, D. (1999) Computer-based approaches to patient education: a review of the literature. Journal of the American Medical Informatics Association.* 272-282.

## IMPROVING PREVENTION COUNSELING

A study at the Sepulveda (CA) VAMC of a consecutive sample of male veterans receiving primary care showed that over two thirds of the patients (68.9%) received some health habit counseling. Counseling rates went up as visit acuity went down; patients with the lowest visit acuity had a 67% greater odds of being counseled than patients with the highest visit acuity. Controlling for other independent variables, patients who reported more risk factors (current smoking or shortness-of-breath, signs of alcohol addition from CAGE assessment, lack of exercise and/or history of diabetes or myocardial infarction) were also more likely to be counseled. While the overall rate of counseling is higher than reported in other studies, only 57.5% of current smokers reported receiving counseling about smoking; 43.6% of patients with an alcohol problem were counseled about alcohol; 37.6% of those not exercising were counseled about exercise; and 40.8% of patients with diabetes or history of heart attack were counseled about diet. The authors highlight the importance of scheduling regular "check-up" visits to ensure that needed counseling is provided to all veterans and that special outreach may be needed for those who routinely use walk-in care.

*Chernoff BA, et al. (1999) Health habit counseling amid competing demands: effects of patient health habits and visit characteristics. Medical Care. 37(8): 783-747.*

## HIV COUNSELING AND TESTING

This study examined results of 27 relatively rigorous studies of the impact of HIV Counseling and Testing (HIV-CT) on sexual risk behaviors-specifically unprotected intercourse, condom use and number of sexual partners. The analysis shows that HIV-CT appears to be an effective means of secondary prevention for HIV positive individuals who reduced unprotected intercourse, increased condom use and reported fewer STDs. However, those individuals who tested negative did not reduce their risk behavior after HIV-CT relative to untested individuals. Since very little information was provided in the research studies about the nature of the counseling provided, it appears that we know little as yet about the types of counseling that might have a beneficial effect for those who test negative. Three participant characteristics impacted the effectiveness of HIV-CT. Older samples increased their condom use more than did younger samples. Second, those who sought HIV-CT reduced their frequency of unprotected intercourse more than those who were offered HIV-CT as part of a research program. Finally, studies that had longer follow up periods had larger effect sizes for number of sexual partners.

*Weinhardt LS, Carey, MP, Johnson BT, and Bickham NL. (1999) Effects of HIV counseling and testing on sexual risk behavior: a meta analytic review of published research, 1985-1987. American Journal of Public Health. 89(9): 1397-1405.*

# PATIENT EDUCATION/ PRIMARY CARE PROGRAM NOTES

## STROKE AWARENESS PROGRAM TARGETS PRIMARY CARE PATIENTS AT RISK FOR FIRST STROKE

Spurred on by the number of veterans experiencing a stroke who delay coming to the hospital for stroke treatment, and the release of consensus recommendations for primary care providers regarding prevention strategies for a first stroke[2] , patient education and neurology staff at the Syracuse NY VAMC are now ready to launch a new stroke awareness program. Targeted to veterans with two or more risk factors for stroke, the one-hour program content focuses on the recognition of symptoms, the importance of early treatment and

2. Gorelick, PB et al. (1999) Prevention of a first stroke: a review of guidelines and a multidisciplinary statement from the National Stroke Association. *JAMA.* 281 (12):1112-1120.

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the identification/management of risk factors. Participants actually do their own risk factor assessment and are asked to designate one behavior they would like to change. This information is documented electronically so that the primary care provider can follow-up with the patient at the next visit. At the end of the class there is time for questions and answers. A clinical pharmacist is available because of many medication questions; a dietitian will soon begin participating in the classes in order to facilitate scheduling appointments for diet-related counseling.

In order to refer patients to the program, primary care providers send a message via the computer documentation system to request a patient education consultation. Program staff will then invite the patient to attend the class. In order to encourage follow-up with the patients regarding behavior change, the nurse educators and case managers for each primary care team (who have designated appointment time for patient education) as well as the primary care clinicians have participated in a special inservice to review the program's goals, content, follow-up options and referral process. Team response was very positive. Members suggested, however, that more than one class per month may be necessary to meet the anticipated need. The developers plan to monitor referral and participation to determine if more classes are needed. Data will also be collected to determine impact of class attendance on the incidence of first stroke and the symptom response time.

The program was recently pilot-tested with a group of veteran volunteers who work at the hospital in order to make sure that the content was appropriate. While the program was very well received, staff were surprised to learn that the participants felt that the content was new. Since this group of veterans is generally well-informed, the test reinforces the initial assessment that the dissemination of information to the lay public about stroke prevention and the need for early treatment has been limited.

*For more information contact:*

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**M. Therese Dean,** BS, Senior Clinical Coordinator, Neurology Service, Syracuse (NY) VAMC; 315/476-7461, Ext. 3816.

**IT IS ESTIMATED THAT 25-50% OF PRIMARY CARE VISITS INVOLVE A PSYCHOLOGICAL OR BEHAVIORAL COMPONENT.**

## MAKING EFFECTIVE REFERRALS FOR MENTAL HEALTH SERVICES IN PRIMARY CARE

It is estimated that 25-50% of primary care visits involve a psychological or behavioral component[3].Examples of such visits include a panic patient with recurrent complaints of chest pain, or a poorly controlled diabetic with erratic adherence to dietary recommendations. Patients with significant psychosocial concerns may contribute to inefficient utilization of medical services, rising health care costs and often require large amounts of health care providers' time. Psychosocial difficulties can be effectively managed by incorporating appropriate mental health referrals into primary care visits. However, patients are often resistant to mental health care, and discussing such referrals can be uncomfortable for health care providers. The following suggestions are intended to enhance primary health care providers' comfort with making mental health care referrals by targeting specific communication strategies that will maximize patients' understanding of the referral process.

1. **Support Current Coping** - Patients cope with adversity by doing what makes sense to them. Acknowledge and encourage whatever reasonable action your patient is taking to cope with their medical condition. Suggest that professionals who specialize in the stressors associated with medical illness may be able to offer additional ways to cope.
2. **Define Mental Health as Part of Primary Care** - By openly discussing the difficulties of living with a medical condition, you demonstrate the relationship between physical and mental health to your patients. When mental health care is presented as

3. See for example Sobel, DS. (1995) Rethinking medicine: improving health outcomes with cost-effective psychosocial interventions. *Psychosomatic Medicine*. 57:34-244.

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essential to comprehensive health care, patients are better able to recognize that their physical symptoms and psychosocial situation may be related.

3. **"Stress Management" Goes a Long Way** - Being "stressed out" is a common household phrase. Patients are often more receptive to mental health services if presented as assistance with managing stress associated with a medical condition, rather than treatment for a psychological problem. The need for stress management is a general statement that can used to describe a variety of mental health services.

4. **Address the Stigma of Mental Health Care** - Many patients fear being considered "crazy." Minimize the stigma of psychological treatment by clearly stating the reason for your referral. Providing a desired outcome from the referral (e.g. better pain management following relaxation training) is likely to have a positive effect on patients' understanding of the need for mental health services.

5. **Check Out the Patient's Reaction** - Take some time to discuss reservations your patients may have about mental health services. Formulate a clear plan about how the patient will access the recommended services to facilitate their follow-up. Finally, ask your patient about the outcome of the referral at the next office visit, and be prepared to gently encourage your patient to pursue the referral if they have not done so.

*Angela Eads, Ph.D., Health Research Scientist at Hines VAMC, Hines, IL submitted this article. She can be contacted at 708/202-2828.*

## NEW FEATURE:

### PERFORMANCE IMPROVEMENT TRAINING

Every quarter, Patient Education in Primary Care will offer the opportunity to earn one hour of performance improvement training credit for a patient education topic of importance to primary care clinicians. To earn this credit choose one of the following two options:

- Read the entire April 2000 newsletter and provide brief answers to the following questions. Turn these in to your supervisor along with a copy of the newsletter

OR

- Organize a one hour brown bag journal club or set aside time during a staff or team meeting to read the newsletter–and discuss the following questions. Turn in a master list of journal club participants along with a copy of the newsletter.

**QUESTIONS:**

1. How aware are patients and staff at your facility about the new pain management initiatives?
2. What activities would be most effective at your VAMC to build awareness of pain management?
3. What ideas do you have for increasing knowledge about early treatment among veterans at risk of stroke?
4. How are primary care staff encouraging patients to follow through with mental health referrals?

***CORRECTION FROM JANUARY 2000 ISSUE:***

**THE HEPATITIS C WEBSITE IS AT**

**www.va.gov/hepatitisc**

## DO YOU HAVE ANY SUCCESSFUL PATIENT EDUCATION STRATEGIES THAT YOU WOULD LIKE TO SHARE WITH US?

Contact Barbara Giloth (773/743-8206 or email bgilot1@uic.edu), Carol Maller (700/572-2400, ext 4656 or email carol.maller@med.va.gov) or Charlene Stokamer (700/662-4218 or email charlene.stokamer@med.va.gov) with your input!

**TELL US ABOUT THE TOPICS YOU WOULD LIKE TO SEE COVERED IN FUTURE ISSUES.**

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**THE NEXT ISSUE WILL BE OUT IN EARLY JULY**

**OFFICE OF PRIMARY AND AMBULATORY CARE**